

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

01-08

2. STATE:

Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

September 1, 2001

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 435.725(c)(1)

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ 6,536,088b. FFY 2003 \$ 6,563,774

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

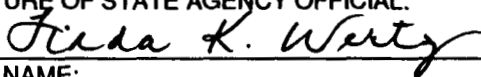
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 603 - This amendment updates the State Plan by increasing
the personal needs allowance of institutionalized clients.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:Sent to Governor's Office this date. Comments,
if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Linda K. Wertz

14. TITLE:

State Medicaid Director

15. DATE SUBMITTED:

August 17, 2001

16. RETURN TO:

Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

August 23, 2001

18. DATE APPROVED:

September 21, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

September 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Calvin G. Cline

22. TITLE: Associate Regional Administrator

Division of Medicaid and State Operations

23. REMARKS:

Attachment to HCFA-179 for
Transmittal No. 01-08 , Amendment No. 603

Number of the
Plan Section or Attachment

Supplement 1 to Attachment 2.2-A
Page 1a

Attachment 2.6-A
Page 4a

Number of the Superseded
Plan Section or Attachment

Supplement 1 to Attachment 2.2-A
Page 1a (TN99-08)

Attachment 2.6-A
Page 4a (TN99-08)

Attachment to Block 7 to HCFA Form 179
Transmittal No. 01-08, Amendment No. 603

The following is the projected expense of increasing the personal needs allowances of institutionalized Medicaid recipients from \$45 to \$60 per month and supplementing the incomes of institutionalized Supplemental Security Income cash recipients who receive the \$30 federal benefit rate by \$30 per month.

| | FY 2002 | FY 2003 | |
|----------------------------------|---------------------|---------------------|-------|
| I. MAO Clients | 60,196 | 60,654 | |
| State | \$ 4,315,692 | \$ 4,359,446 | |
| Federal | \$ <u>6,519,588</u> | \$ <u>6,558,274</u> | Total |
| 10,835,280 | 10,917,720 | | |
| II. SSI Clients | 12,295 | 12,216 | |
| State | \$ 2,213,100 | \$ 2,198,880 | |
| Federal | <u>0</u> | <u>0</u> | |
| Total | \$ 2,213,100 | \$ 2,198,880 | |
| III Automation/Programming Hours | | | |
| | 300 hours | 100 hours | |
| cost/hour | \$ <u>110</u> | \$ <u>110</u> | |
| | \$ 33,000 | \$ 11,000 | |
| State | \$ 16,500 | \$ 5,500 | |
| Federal | \$ <u>16,500</u> | \$ <u>5,500</u> | |
| Total | \$ 33,000 | \$ 11,000 | |
| IV Total Costs | | | |
| State | \$ 6,545,292 | \$ 6,563,826 | |
| Federal | \$ <u>6,536,088</u> | \$ <u>6,563,774</u> | |
| Total | \$ 13,081,380 | \$ 13,127,600 | |

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 1 TO ATTACHMENT 2-2-A
Page 1a
OMB NO: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

REASONABLE CLASSIFICATIONS OF INDIVIDUALS
RECEIVING STATE SUPPLEMENTATION

Institutionalized Supplemental Security Income cash recipients who receive the \$30 federal benefit rate also receive a \$30 per month state supplementation check.

| | |
|-----------------------------|--|
| A | |
| STATE <u>Texas</u> | |
| DATE REC'D <u>08-23-01</u> | |
| DATE APPV'D <u>09-21-01</u> | |
| DATE EFF <u>09-01-01</u> | |
| HCFA 179 <u>TX-01-08</u> | |

TN No. 01-08

Supersedes Approval Date 09-21-01 Effective Date 09-01-01

No. 99-08

State: Texas

| Citation | Condition or Requirement |
|--|--|
| 1924 of the Act 435.725 435.733 435.832 | 2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons. |

- a. Aged, blind, disabled:
Individuals \$ 60.00
Couples \$ 120.00

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the organizational unit which determines that a criterion is met.

- b. TANF related:
Children \$ Benefit level as specified in Title IV State Plan
Adults \$ Benefit level as specified in Title IV State Plan

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the organizational unit which determines that a criterion is met.

- c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2-A.
\$ _____

| | |
|-------------|----------|
| A | |
| STATE | Texas |
| DATE REC'D | 08-23-01 |
| DATE APPV'D | 09-21-01 |
| DATE EFF | 09-01-01 |
| HCFA 179 | TX-01-08 |



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Calvin G. Cline

Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 833
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0322

September 21, 2001

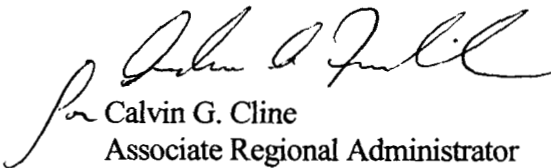
Our Reference: **SPA-TX-01-08**

Ms. Linda K. Wertz, State Medicaid Director
Texas Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

Dear Ms. Wertz:

We have enclosed a copy of HCFA-179, **Transmittal Number 01-08**, dated August 17, 2001. This amendment updates the State Plan by increasing the personal needs allowance of institutionalized Medicaid recipients from \$45.00 to \$60.00 per month. We have approved the amendment for incorporation into the official Texas State Plan **effective September 1, 2001**. If you have any questions, please call Shirley Glaspie at (214) 767-6407.

Sincerely,



Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosures

cc: Elliott Wesiman, CMSO, PCPG
Commerce Clearing House